FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040022

Facility Name: California Gardens N & Rehab C

Address: 2829 South California Blvd (Number) Chicago (City) 60608 (Zip Code)

County: Cook

Telephone Number: (773) 847-8061 **Fax #** (773) 847-1603

HFS ID Number: 363961687001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	293	Skilled (SNF)	293	106,945	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	293	TOTALS	293	106,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	93,558	1,237	7,050	101,845	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	93,558	1,237	7,050	101,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.23%

D. How many bed-hold days during this year were paid by the Department?
2,371 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 293 and days of care provided 5,759

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/05 Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	372,931	93,397	11,520	477,848		477,848		477,848			1
2	Food Purchase		466,468		466,468	(1,664)	464,804	(381)	464,423			2
3	Housekeeping		64,610	402,588	467,198		467,198		467,198			3
4	Laundry		20,128		20,128		20,128		20,128			4
5	Heat and Other Utilities			232,966	232,966		232,966	3,854	236,820			5
6	Maintenance	200,628	21,176	89,104	310,908		310,908	653	311,561			6
7	Other (specify):*											7
8	**TOTAL General Services**	573,559	665,779	736,178	1,975,516	(1,664)	1,973,852	4,126	1,977,978			8
	B. Health Care and Programs											
9	Medical Director			38,400	38,400		38,400		38,400			9
10	Nursing and Medical Records	3,150,563	232,233	10,725	3,393,521		3,393,521	(3,501)	3,390,020			10
10a	Therapy	98,979		10,857	109,836		109,836		109,836			10a
11	Activities	83,406	10,945	2,403	96,754		96,754		96,754			11
12	Social Services	79,874		2,093	81,967		81,967		81,967			12
13	CNA Training											13
14	Program Transportation	39,254		2,219	41,473		41,473		41,473			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,452,076	243,178	66,697	3,761,951		3,761,951	(3,501)	3,758,450			16
	C. General Administration											
17	Administrative	167,348		905,084	1,072,432		1,072,432	(855,039)	217,393			17
18	Directors Fees											18
19	Professional Services			159,154	159,154		159,154	(2,665)	156,489			19
20	Dues, Fees, Subscriptions & Promotions			103,086	103,086		103,086	(67,588)	35,498			20
21	Clerical & General Office Expenses	262,139	47,488	294,517	604,144		604,144	(17,724)	586,420			21
22	Employee Benefits & Payroll Taxes			723,355	723,355	1,664	725,019		725,019			22
23	Inservice Training & Education			2,175	2,175		2,175		2,175			23
24	Travel and Seminar			6,178	6,178		6,178	146	6,324			24
25	Other Admin. Staff Transportation			3,024	3,024		3,024	524	3,548			25
26	Insurance-Prop.Liab.Malpractice			427,205	427,205		427,205	15,740	442,945			26
27	Other (specify):*							39,157	39,157			27
28	**TOTAL General Administration**	429,487	47,488	2,623,778	3,100,753	1,664	3,102,417	(887,449)	2,214,968			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,455,122	956,445	3,426,653	8,838,220		8,838,220	(886,824)	7,951,396			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number California Gardens N & Rehab C #0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			120,879	120,879		120,879	189,955	310,834			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			139,793	139,793		139,793	755,723	895,516			32
33	Real Estate Taxes			(7,281)	(7,281)		(7,281)	316,655	309,374			33
34	Rent-Facility & Grounds			2,219,879	2,219,879		2,219,879	(2,219,234)	645			34
35	Rent-Equipment & Vehicles			7,760	7,760		7,760	4,465	12,225			35
36	Other (specify):*							135,442	135,442			36
37	**TOTAL Ownership**			2,481,030	2,481,030		2,481,030	(816,994)	1,664,036			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	4,856	185,683	748,092	938,631		938,631		938,631			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,418	160,418		160,418		160,418			42
43	Other (specify):*	95,803		4,078	99,881		99,881	(99,881)				43
44	**TOTAL Special Cost Centers**	100,659	185,683	912,588	1,198,930		1,198,930	(99,881)	1,099,049			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,555,781	1,142,128	6,820,271	12,518,180		12,518,180	(1,803,699)	10,714,481			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(54,468)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(21,266)	21		18
19	Entertainment	(703)	24		19
20	Contributions	(16,874)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(202,013)	21		24
25	Fund Raising, Advertising and Promotional	(48,876)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(120,663)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (464,920)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,338,779)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,338,779)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,803,699)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

California Gardens N & Rehab C

ID# 0040022

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VA Expenses	$ (665)	10	1
2	Patient Needs	(2,698)	10	2
3	Copying Income	(916)	21	3
4	Jury Duty Income	(138)	10	4
5	SBC	(99)	21	5
6	Food Rebates	(324)	02	6
7	Misc Income	(15)	21	7
8	2005 Seminar	29	24	8
9	Marketing Consultant	(4,078)	43	9
10	COPE Dues	(3,923)	20	10
11	Annual Report	(325)	20	11
12	Non-Allowable Legal	(6,529)	19	12
13	Marketing Salary	(72,914)	43	13
14	Non-Allowable Salary	(22,869)	43	14
15	Capitalized R&M	(4,679)	06	15
16	Network Fees	(500)	19	16
17				17
18				18
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100				100
101	**Total**	(120,663)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N & Rehab C # 0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(381)											(381)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			3,854									3,854	5
6	Maintenance	(4,679)		5,332									653	6
7	Other (specify):*													7
8	**TOTAL General Services**	(5,060)		9,186									4,126	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,501)											(3,501)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(3,501)											(3,501)	16
	C. General Administration													
17	Administrative			(855,039)									(855,039)	17
18	Directors Fees													18
19	Professional Services	(7,029)		4,364									(2,665)	19
20	Fees, Subscriptions & Promotions	(69,998)		2,410									(67,588)	20
21	Clerical & General Office Expenses	(224,309)		206,585									(17,724)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(674)		820									146	24
25	Other Admin. Staff Transportation			524									524	25
26	Insurance-Prop.Liab.Malpractice		8,438	7,302									15,740	26
27	Other (specify):*			39,157									39,157	27
28	**TOTAL General Administration**	(302,010)	8,438	(593,877)									(887,449)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(310,571)	8,438	(584,691)									(886,824)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number California Gardens N & Rehab C **#** 0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(54,468)	232,517	11,906									189,955	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		754,093	1,630									755,723	32
33	Real Estate Taxes		313,418	3,237									316,655	33
34	Rent-Facility & Grounds		(2,219,879)	645									(2,219,234)	34
35	Rent-Equipment & Vehicles			4,465									4,465	35
36	Other (specify):*		135,442										135,442	36
37	TOTAL Ownership	(54,468)	(784,409)	21,883									(816,994)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(99,881)											(99,881)	43
44	TOTAL Special Cost Centers	(99,881)											(99,881)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(464,920)	(775,971)	(562,808)									(1,803,699)	45

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				California Associates		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 2,219,879	California Associates	100.00%	$	$ (2,219,879)	1
2	V	32	Interest	2,991	California Associates	100.00%	757,084	754,093	2
3	V	36	MIP		California Associates	100.00%	135,442	135,442	3
4	V	30	Depreciation		California Associates	100.00%	232,517	232,517	4
5	V	33	Real Estate Taxes		California Associates	100.00%	313,418	313,418	5
6	V	26	Property and Liability Ins.		California Associates	100.00%	8,438	8,438	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,222,870			$ 1,446,899	$ * (775,971)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 3,854	$ 3,854	15
16	V	6	REPAIRS AND MAINT.				5,332	5,332	16
17	V	17	ADMINISTRATIVE - NON-OWNER				28,334	28,334	17
18	V	19	PROFESSIONAL FEES				4,364	4,364	18
19	V	20	FEES SUBSCRIPTIONS				2,410	2,410	19
20	V	21	CLERICAL & GENERAL				206,585	206,585	20
21	V	24	SEMINARS AND EDUCATION				820	820	21
22	V	25	ADMIN. STAFF TRAVEL				524	524	22
23	V	26	INSURANCE				7,302	7,302	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.				36,072	36,072	24
25	V	30	DEPRECIATION				11,906	11,906	25
26	V	32	INTEREST EXPENSE				1,630	1,630	26
27	V	33	REAL ESTATE TAX				3,237	3,237	27
28	V	34	BUILDING RENT				645	645	28
29	V	35	EQUIPMENT RENTAL				4,465	4,465	29
30	V	17	ADMIN. - R. HARTMAN				5,913	5,913	30
31	V	17	ADMIN. - B. CARR				15,798	15,798	31
32	V	17	ADMIN. - D. HARTMAN						32
33	V	27	EMP. BEN. - R. HARTMAN				2,011	2,011	33
34	V	27	EMP. BEN. - B. CARR				1,074	1,074	34
35	V	27	EMP. BEN. - D. HARTMAN						35
36	V								36
37	V	17	MANAGEMENT FEES	905,084				(905,084)	37
38	V								38
39	Total			$ 905,084			$ 342,276	$ * (562,808)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	Workmans Comp	$ 66,507	Diamond Insurance	100.00%	$ 66,507	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 66,507			$ 66,507	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	57.48%	See Attached	2.37	4.74%	Allocated	$ 5,913	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	5.91	11.82%	Allocated	15,798	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,711		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	904,250	11	$ 32,587	$	106,945	$ 3,854	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	904,250	11	45,083		106,945	5,332	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	904,250	11	239,568	232,849	106,945	28,334	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	904,250	11	36,902		106,945	4,364	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	904,250	11	20,379		106,945	2,410	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	904,250	11	1,746,738	1,454,049	106,945	206,585	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	904,250	11	6,935		106,945	820	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	904,250	11	4,428		106,945	524	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	904,250	11	61,742		106,945	7,302	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	904,250	11	304,996		106,945	36,072	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	904,250	11	100,669		106,945	11,906	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	904,250	11	13,784		106,945	1,630	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	904,250	11	27,371		106,945	3,237	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS	904,250	11	5,450		106,945	645	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	904,250	11	37,756		106,945	4,465	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	11	50,000	50,000	2	5,913	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED	50	11	133,580	133,580	6	15,798	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	40	2	4,069	4,069			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	11	17,006		2	2,011	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	50	11	9,079		6	1,074	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	40	2	4,925				21
22										22
23										23
24										24
25	TOTALS					$ 2,903,047	$ 1,874,548		$ 342,276	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd, Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation			$	$		$ 66,507	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 66,507	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage			$	$ 14,713,619			$ 757,084	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholder Loan		X	Working Capital	Interest Only			4,136,744			139,793	6
7	Allocated from Nucare		X								1,630	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 18,850,363			$ 898,507	9
	B. Non-Facility Related*											
10	Allocated - Bldg Co										(2,991)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (2,991)	14
15	TOTALS (line 9+line14)						$	$ 18,850,363			$ 895,516	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 135,442 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number California Gardens N & Rehab C **#** 0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	378,193	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	370,418	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,775)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	317,148	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	309,373	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	391,485	8
	2001	401,667	9
	2002	406,170	10
	2003	359,202	11
	2004	367,181	12

2005 R/E Tax Accrual per client records
Nucare Allocation = 2719

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & Rehab C COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-25-401-015-0000	Long Term Care	$ 367,181.30	$ 367,181.30
2.	10-27-319-028-0000	Home Office (see attached)	$ 22,998.06	$ 2,719.96
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 390,179.36	$ 369,901.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & Rehab C COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,844 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Faciltiy	193,025	1987	$ 300,000	1
2	7257 N. Lincoln		2004	9,212	2
3	TOTALS	193,025		$ 309,212	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1981	4,471		20			205	9
10	Various			1982	2,319		20			222	10
11	Various			1983	10,829		20			1,580	11
12	Various			1984	1,410		20			277	12
13	Various			1985	17,805		20	92	92	492	13
14	Various			1986	22,863		20	1,143	1,143	5,716	14
15	Various			1987	40,100		20	2,005	2,005	10,025	15
16	Various			1988	2,787		20	139	139	2,381	16
17	Various			1989	3,024		20	151	151	756	17
18	Various			1990	8,652		20	433	433	2,163	18
19	Various			1991	3,892		20	195	195	973	19
20	Various			1993	24,138		20	1,207	1,207	6,035	20
21	Various			1994	8,195		20	410	410	2,049	21
22	Various			1995	17,230		20	863	863	9,185	22
23	Various			1996	46,848		20	2,342	2,342	21,780	23
24	Various			1997	70,702		20	3,591	3,591	30,785	24
25	Various			1998	33,854		20	1,695	1,695	12,778	25
26	Various			1999	103,092		20	5,227	5,227	33,851	26
27	Various			2000	194,600		20	9,736	9,736	56,401	27
28	Various			2001	75,921		20	4,117	4,117	18,528	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,708,760	232,517		176,340	(56,177)	1,476	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		123,289	5,525		4,157	(1,368)	7,939	68
69	Financial Statement Depreciation			63,165			(63,165)		69
70	TOTAL (lines 4 thru 69)		$ 5,524,781	$ 301,207		$ 213,843	$ (87,364)	$ 225,597	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,524,781	$ 301,207		$ 213,843	$ (87,364)	$ 225,597	1
2	Boiler	2002	4,779		20	478	478	1,832	2
3	Canopy	2002	1,817		20	182	182	681	3
4	Wanderguard System	2002	1,973		20	197	197	723	4
5	Phone Line Install	2002	5,446		20	545	545	2,042	5
6	Resurface Lot/Sidewalk	2002	25,274		20	1,685	1,685	5,616	6
7	Exit Sign	2002	1,275		20	128	128	425	7
8	Phone Line Install	2002	1,868		20	187	187	607	8
9	Fire Pump	2002	2,730		20	273	273	887	9
10	Sign Fixture	2003	987		20	99	99	280	10
11	Loc System	2003	1,338		20	191	191	573	11
12	Cat5 Run	2003	1,025		20	146	146	390	12
13	Cctv System	2003	1,516		20	217	217	650	13
14	Telephone Lines	2003	907		20	91	91	272	14
15	Telephone Lines	2003	860		20	86	86	258	15
16	Cctv Monitors	2003	1,151		20	164	164	493	16
17	Monitoring System	2003	2,908		20	415	415	1,246	17
18	Lanscaping	2003	23,600		20	1,573	1,573	4,720	18
19	Landscaping	2003	590		20	39	39	118	19
20	Landscaping	2003	400		20	27	27	80	20
21	Repair Elevator	2003	1,054		20	53	53	127	21
22	Repair Elevator	2003	1,878		20	94	94	227	22
23	Door Alarm	2003	1,228		20	175	175	409	23
24	Cctv To Monitor	2003	1,079		20	154	154	360	24
25	Dr Alarm	2003	1,147		20	164	164	369	25
26	Sprinkler Heads	2003	1,000		20	67	67	150	26
27	Repair Elevator	2003	5,236		20	262	262	567	27
28	Cctv To Monitor	2003	4,660		20	666	666	1,442	28
29	Exterior Lights	2003	877		20	88	88	190	29
30	Elevator Repairs	2003	507		20	25	25	68	30
31	Elevator Repairs	2003	717		20	36	36	78	31
32	Fire Alarm Repairs	2003	739		20	37	37	105	32
33	Installed Cctv Monitor	2004	1,873		20	48	48	94	33
34	TOTAL (lines 1 thru 33)		$ 5,627,220	$ 301,207		$ 222,435	$ (78,772)	$ 251,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,627,220	$ 301,207		$ 222,435	$ (78,772)	$ 251,676	1
2	Eletronic Work For Reception Desk	2004	1,379		20	35	35	66	2
3	Installed Cctv - Outside Back Parking Lot	2004	1,380		20	138	138	264	3
4	Installed Alarm Control At Reception	2004	1,728		20	173	173	317	4
5	Alarm System Service	2004	998		20	100	100	191	5
6	Installed Monitoring System	2004	1,281		20	128	128	245	6
7	Telephone Wiring	2004	820		20	82	82	157	7
8	2 V-Shaped Signs	2004	13,000		20	1,300	1,300	1,408	8
9	10 Schlage Standard Duty Door Knobs	2004	879		20	88	88	154	9
10	Installed Alarm Reset Control Box	2004	896		20	90	90	164	10
11	Installed Telephone Lines And Outlets	2004	825		20	83	83	138	11
12	Installed 2 Pull Stations And Service	2004	759		20	76	76	152	12
13	Installed Digital Keypad	2004	597		20	60	60	119	13
14	Installed Video Processor And Service	2004	942		20	94	94	188	14
15	Installed Alarm Reset Key Switch	2004	782		20	78	78	111	15
16	Roof Repair & Reseal Deposit	2004	1,500		20	38	38	64	16
17	Additional Roof Repair Deposit	2004	1,000		20	26	26	38	17
18	Additional Roof Repair And Remaining Balance Due	2004	7,600		20	195	195	276	18
19	Overtime Service Call 3 Hrs	2004	1,090		20	54	54	73	19
20	Telephone Repair Service	2004	825		20	41	41	58	20
21	Exterior Lighting Repairs	2004	787		20	39	39	46	21
22	Cctv Repairs	2004	760		20	38	38	76	22
23	Generator Repairs	2004	703		20	35	35	53	23
24	Glass Repairs	2004	815		20	41	41	61	24
25	Repair Wiring For Smoke Detectors	2004	552		20	28	28	30	25
26	Replaced Elevator Door Tracks	2004	5,253		20	135	135	157	26
27	Light Fixtures*	2005	10,837		20	993	993	993	27
28	New Data Cables*	2005	1,567		20	118	118	118	28
29	Concrete Installation*	2005	16,568		20	1,243	1,243	1,243	29
30	Elevator Car Station - Fire Service Upgrade*	2005	60,648		20	4,043	4,043	4,043	30
31	Elevator Recall Face*	2005	10,819		20	811	811	811	31
32	Nursing Station And Medical Room For 2 Floors*	2005	24,800		20	1,653	1,653	1,653	32
33	Cctv For Monitoring System	2005	1,592		20	227	227	227	33
34	TOTAL (lines 1 thru 33)		$ 5,801,202	$ 301,207		$ 234,718	$ (66,489)	$ 265,370	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,801,202	$ 301,207		$ 234,718	$ (66,489)	$ 265,370	1
2	Cctv For Monitoring System	2005	983		20	140	140	140	2
3	A/C Motor Lincoln	2005	1,728		20	144	144	144	3
4	Polish Wire Glass For Dining Room	2005	620		20	31	31	31	4
5	Carpeting Installation	2005	850		20	51	51	51	5
6	Front Reception Window Granite Tops And Employee Lunch Roon	2005	8,000		20	333	333	333	6
7	Elevator Passenger Car Wiring	2005	8,083		20	269	269	269	7
8	Wireless Annunciator And Motion Detector	2005	1,181		20	70	70	70	8
9	Cctv For Monitoring System	2005	1,137		20	68	68	68	9
10	Smoke Detector	2005	956		20	68	68	68	10
11	New Packing And Valve	2005	6,081		20	152	152	152	11
12	Elevator Repair*	2005	882		20	44	44	44	12
13	Nurse Call System *	2005	1,280		20	64	64	64	13
14	Drywall*	2005	515		20	26	26	26	14
15	Vinyl Tiel And Adhesive*	2005	677		20	34	34	34	15
16	Service On Monitor System*	2005	1,325		20	66	66	66	16
17	Ceiling Tile	2005	2,040		20	43	43	43	17
18	Break Room And Barber Shop	2005	3,200		20	80	80	80	18
19	Wiring	2005	4,026		20	34	34	34	19
20	Security Monitoring System	2005	6,215		20	518	518	518	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,850,981	$ 301,207		$ 236,953	$ (64,254)	$ 267,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998	1977	$ 4,708,760	$ 232,517	35	$ 176,340	$ (56,177)	$ 1,476	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,708,760	$ 232,517		$ 176,340	$ (56,177)	$ 1,476	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2004	2004	$ 82,906	$ 2,126	35	$ 2,369	$ 243	$ 5,034	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Nucare			2003	1,385	69	20	69		147	9
10	Allocated from Nucare			2004	28,125	1,406	20	1,406		2,403	10
11	Allocated from Nucare			2005	1,667	465	20	42	(423)	42	11
12											12
13	Allocated from 7257 N. Lincoln Avenue, LLC			2004	1,648	932	20	82	(850)	124	13
14	Allocated from 7257 N. Lincoln Avenue, LLC			2005	7,558	527	20	189	(338)	189	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 123,289	$ 5,525		$ 4,157	$ (1,368)	$ 7,939	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 634,295	$ 56,554	$ 67,183	$ 10,629	10	$ 363,091	71
72	Current Year Purchases	83,955	5,766	6,698	932	10	6,698	72
73	Fully Depreciated Assets	54,515				10	54,515	73
74								74
75	TOTALS	$ 772,765	$ 62,320	$ 73,881	$ 11,561		$ 424,304	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 FORD WAGON	1997	$ 21,161	$ 1,775	$	$ (1,775)	5	$ 21,160	76
77										77
78										78
79										79
80	TOTALS			$ 21,161	$ 1,775	$	$ (1,775)		$ 21,160	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,954,119	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 365,302	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 310,834	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (54,468)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 713,069	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nu Vision Holding
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 2,219,879			3
4	Additions							4
5	Allocated from Nucare				645			5
6	Alloc-California Associates				(2,219,879)			6
7	TOTAL				$ 645 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 12,225 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 331,114	$		$ 331,114	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			68,858			68,858	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			341,028			341,028	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				133,100		133,100	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					318		318	12
13	Other (specify): See Supplemental			4,856		7,092	52,265		64,213	13
14	TOTAL			$ 4,856		$ 748,092	$ 185,683		$ 938,631	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$ 281,632	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,339,062	3,454,908	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	232,278	232,278	6
7	Other Prepaid Expenses	17,132	82,003	7
8	Accounts Receivable (owners or related parties)	1,818,280	1,818,280	8
9	Other(specify): See Attached Schedule	6,032	997,665	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,413,184	$ 6,866,766	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,151,920	13
14	Buildings, at Historical Cost		3,973,900	14
15	Leasehold Improvements, at Historical Cost	868,636	1,557,282	15
16	Equipment, at Historical Cost	707,372	5,814,775	16
17	Accumulated Depreciation (book methods)	(912,311)	(5,116,933)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		221,853	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	76,913	76,913	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 740,610	$ 7,679,710	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,153,794	$ 14,546,476	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,100,893	$ 1,103,261	26
27	Officer's Accounts Payable		112,358	27
28	Accounts Payable-Patient Deposits	198	198	28
29	Short-Term Notes Payable	4,136,744	4,136,744	29
30	Accrued Salaries Payable	356,910	356,910	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,040	27,040	31
32	Accrued Real Estate Taxes(Sch.IX-B)		317,148	32
33	Accrued Interest Payable		62,778	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	33,756	33,756	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	15,163	15,163	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,670,704	$ 6,165,356	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,713,619	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 14,713,619	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,670,704	$ 20,878,975	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 483,090	$ (6,332,499)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,153,794	$ 14,546,476	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number California Gardens N & Rehab C **#** 0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 354,358	1
2	Restatements (describe):		2
3	**Management Fee**	(57,578)	3
4	**Vacation Pay**	38,622	4
5	**Bad Debt**	(431,217)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (95,815)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	578,905	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 578,905	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 483,090	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,606,287	1
2	Discounts and Allowances for all Levels	(388,215)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,218,072	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,495,366	6
7	Oxygen	1,494	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,496,860	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	248,726	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,765	19
20	Radiology and X-Ray	4,327	20
21	Other Medical Services	102,844	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 380,662	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,491	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,491	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,097,085	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,975,516	31
32	Health Care	3,761,951	32
33	General Administration	3,100,753	33
	B. Capital Expense		
34	Ownership	2,481,030	34
	C. Ancillary Expense		
35	Special Cost Centers	1,038,512	35
36	Provider Participation Fee	160,418	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,518,180	40
41	**Income before Income Taxes (line 30 minus line 40)****	578,905	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 578,905	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,863	2,498	$ 114,423	$ 45.81	1
2	Assistant Director of Nursing	3,069	4,131	129,438	31.33	2
3	Registered Nurses	35,759	37,979	945,404	24.89	3
4	Licensed Practical Nurses	31,830	34,626	707,317	20.43	4
5	CNAs & Orderlies	106,370	115,899	1,041,344	8.98	5
6	CNA Trainees					6
7	Licensed Therapist	209	209	4,856	23.23	7
8	Rehab/Therapy Aides	8,379	9,333	98,979	10.61	8
9	Activity Director	1,095	1,227	19,249	15.69	9
10	Activity Assistants	7,382	7,805	64,157	8.22	10
11	Social Service Workers	4,010	4,298	79,874	18.58	11
12	Dietician	3,953	4,291	85,384	19.90	12
13	Food Service Supervisor					13
14	Head Cook	9,802	10,745	127,528	11.87	14
15	Cook Helpers/Assistants	17,750	19,059	160,019	8.40	15
16	Dishwashers					16
17	Maintenance Workers	9,230	9,836	200,628	20.40	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,943	2,086	112,985	54.16	20
21	Assistant Administrator					21
22	Other Administrative	873	873	54,363	62.27	22
23	Office Manager					23
24	Clerical	11,584	12,328	262,139	21.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,719	11,566	145,154	12.55	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,388	7,026	67,483	9.60	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,512	4,635	135,057	29.14	33
34	TOTAL (lines 1 - 33)	276,720	300,450	$ 4,555,781 *	$ 15.16	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,520	01-03	35
36	Medical Director	Monthly	38,400	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	23	573	10-03	38
39	Pharmacist Consultant	Monthly	5,928	10-03	39
40	Physical Therapy Consultant	70	3,158	10a-03	40
41	Occupational Therapy Consultant	28	1,261	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	878	10a-03	43
44	Activity Consultant	100	2,403	11-03	44
45	Social Service Consultant	39	2,093	12-03	45
46	Other(specify)				46
47	DD Therapy Consultant	85	5,560	10a-03	47
48	3314	9,429			48
49	TOTAL (lines 35 - 48)	9,793	$ 75,998		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rick Walworth	Administrator	0.00	$ 112,985
Kathleen Brander	VP Regulator Mgmt	0.00	16,930
Marilyn Flaherty	VP Medicare Reimb	0.00	19,668
Jennifer Bebinger	Alz Unit Director	0.00	17,765
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 167,348

B. Administrative - Other

Description	Amount
NuCare Services Corp - Management Services	$ 905,084
TOTAL (agree to Schedule V, line 17, col. 3)	$ 905,084
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Annie Walker	Settlement	$ 2,250
FR&R	Accounting	33,589
CDW	Computer Services	3,825
Giftrap	Computer Services	5,801
Emdeon Business Services	Consulting	561
HDSI	Computer Services	7,714
PSD Solutions	Computer Services	6,936
Carepath - Adj Page 5	Network Services	500
Purchasing Plus	Purchase Consultant	150
Personnel Planners	Unemployment Consulting	4,549
See Attached	Legal	93,217
National Datacare	Computer Services	62
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 159,154

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,507
Unemployment Compensation Insurance	97,873
FICA Taxes	313,246
Employee Health Insurance	174,002
Employee Meals	1,664
Illinois Municipal Retirement Fund (IMRF)*	
Head Tax	7,264
Pension Benefits	32,102
Dental	3,600
401K Matching Expense	5,542
Other Employee Benefits	23,219
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,019

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	8,239
Health Care Worker Background Check	3,000
(Indicate # of checks performed 300)	
Association Dues	3,663
Dues and Subscriptions	14,972
Licenses and Inspections	2,220
Advertising and Promotion	48,876
Allocated from Nucare	2,410
Less: Public Relations Expense	( )
Non-allowable advertising	(48,876)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,498

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,504
Allocated from Nucare	820
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,324

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C # 0040022 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC-$3,662.50**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,928** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **160,418**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,664** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.